Intake form

Shakti Qi ACUPUNCTURE

To assist in providing you with the best possible care, please fill out this form as accurately as you can. All the information provided will be kept confidential in your patient's file.

Today's Date: _____

Patient Information

Name (legal name): _____ Date of Birth: _____ Age: _____

Address: _____ City: _____ Postal Code: _____

Home Phone: _____ Mobile Phone: _____ Work Phone: _____

Email: _____ Occupation: _____

Gender: _____ Partnership Status: _____ No. of Children: _____ No. Adopted: _____

Primary Physician: _____ Phone: _____ Clinic: _____

Emergency Contact: _____ Phone: _____ Relationship: _____

Reason for Today's Visit

(list concerns, when and where it started, how long it's been there, if it affects your work or sleep, if it's getting worse, etc.)

1. _____

2. _____

3. _____

Please indicate any current or previous therapies tried for these concerns: _____

Are you currently under a physician's care? ☐ Yes ☐ No If **Yes**, for what? _____

Have you or are you on other kinds treatments with other practitioners for this this or any other concerns? ☐ Yes ☐ No

If **Yes**, please let us know with whom, where and for what and treatment methods _____

Is this your first time with Acupuncture or Traditional Chinese Medicine (TCM)? ☐ Yes ☐ No If **No**, please let us know with whom, when and where? _____

How did you find us? ☐ Internet search ☐ Social Media. ☐ Walk by. ☐ Family. ☐ Friend. ☐ Health Practitioner

Whom should we thank for referring you to us? _____

Personal Medical History:

Past and current medical diagnosis (given by certified medical professional), include date diagnosed _____

Surgeries, Major Illnesses, Hospitalizations, Major Accidents (include dates): _____

Are you scheduled for an upcoming surgery? If so, when and for what? _____

Please inform the practitioner if any of the following apply to you: ☐ Haemophiliac ☐ Epilepsy ☐ A serious lung condition ☐ A serious heart condition Your HIV status _____ ☐ Wear a pacemaker or other mechanical devices? If so what? _____ ☐ Do you have any metal implants? (e.g. plate, screws, etc.) If so what? _____

Are you pregnant or is there any chance you might be? _____ If **yes** how many weeks? _____

Please, list prescription drugs you are currently taking, for what and doses: _____

Please list any supplement, over the counter or herbal medicines you are currently taking and doses: _____

Please list any allergies you may have: _____

Immediate Family Medical History (Biological parents and siblings)

Please list conditions and with which parent or sibling: _____

General Lifestyle Information:

Personal Information: Height: _____ Weight: _____

Diet: Briefly describe your diet, or indicate if you are on a special medical diet: _____

Concerns about your diet? _____

Crave any particular foods or tastes? _____

Drinks: How much and often do you take any of the following? Water: _____ Coffee: _____ Black Tea: _____ Herbal Tea: _____ Alcohol: _____ Type: _____ Other drinks: _____

Smoking: Have you ever been a smoker? ☐ Yes ☐ No How long? Tobacco Type: Per day? Recreational Drugs? ☐ Yes ☐ No How long? Type: Per day?

Bowel Movements: Times per day: Type of stools: General colour? Any smell? Any sensations? Other (please specify):

Urine: Times per day: General colour? Any smell? Any sensations? More than twice at night? ☐ Yes ☐ No If **yes**, how many times? Urinate because waking up or wake up to urinate? Other (please specify):

Sleep: Hours per night Rested in AM? Dreams? Trouble staying asleep? No. times wake up? Times wake up? Trouble falling asleep?

Other (please specify):

Exercise: Do you exercise? ☐ Yes ☐ No How often? Type(s)?

Thank you for taking the time to fill out this form thoroughly and to the best of your knowledge.

Tel: 604 724 4986 email: info@shaktiqi.com web: www.shaktiqi.com

Emotions: Generally, what kind of feelings do you feel?

What makes it better? _____ What makes it worse? _____

Stress: **average**:1 2 3 4 5 6 7 8 9 10 **right now**: 1 2 3 4 5 6 7 8 9 10

What makes it better? _____ What makes it worse? _____

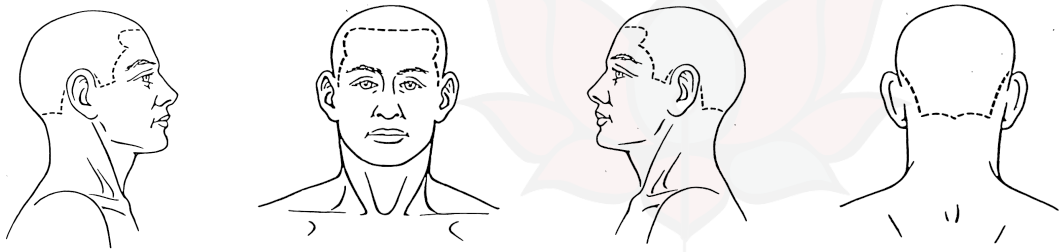
Energy: **average**:1 2 3 4 5 6 7 8 9 10 **right now**: 1 2 3 4 5 6 7 8 9 10

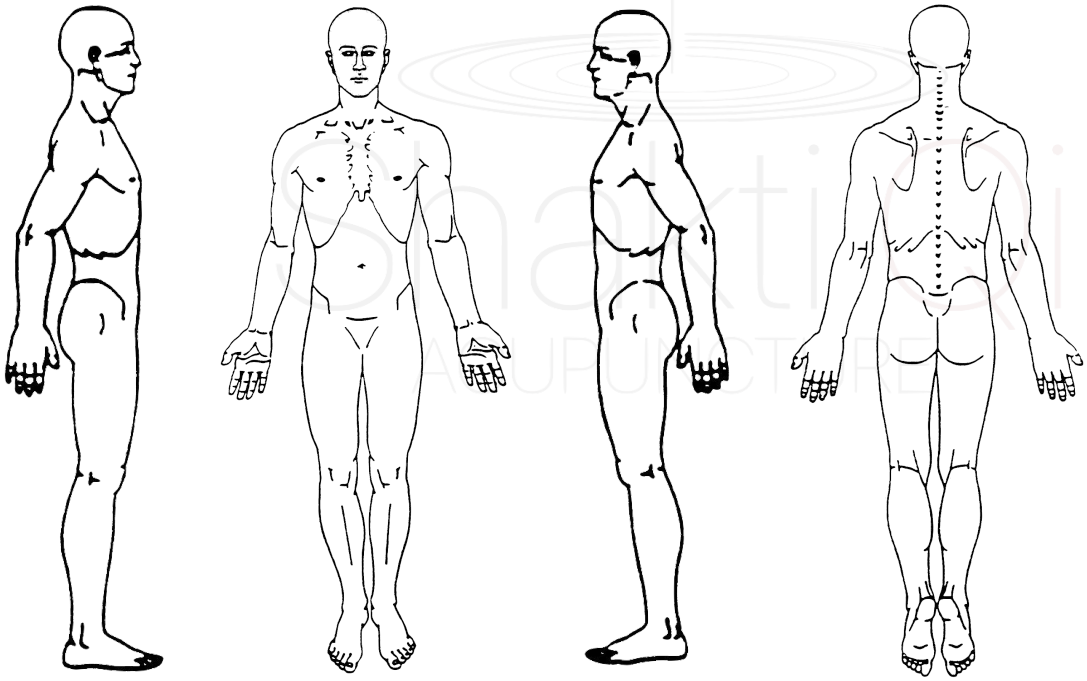
What makes it better? _____ What makes it worse? _____

Work: Enjoy work? ☐ Yes ☐ No Hours per week working _____

Hobbies: _____

On the figures below, please indicate and colour your areas of pain/concern





T - tenderness
A - aches
P - pins/needles
R - radiation
B - burning
X - stabbing
N/T - numbing/tingling
C/S - cramping/spasm
O – Other: _____
_____

Best describes your discomfort since the last visit at its ...

worst: 1 2 3 4 5 6 7 8 9 10 **least**: 1 2 3 4 5 6 7 8 9 10

average: 1 2 3 4 5 6 7 8 9 10 **right now**: 1 2 3 4 5 6 7 8 9 10

Briefly, what makes your discomfort worse or better? _____

Please check any of the following conditions that you currently (C) suffer from, or have a medical history (H) of

- [ ] Alcoholism
- [ ] Anemia
- [ ] Glaucoma
- [ ] Fibromyalgia
- [ ] Contagious illness
- [ ] Angina
- [ ] Blood Pressure: Low
- [ ] Deep Vein Thrombosis
- [ ] Jaw pain
- [ ] Irregular Pulse
- [ ] Digestive Disorders
- [ ] Spinal Injury
- [ ] Multiple Sclerosis
- [ ] Gall Stones
- [ ] Liver disease
- [ ] Thyroid Disorders
- [ ] Drug Dependence
- [ ] Osteoporosis
- [ ] Ulcers
- [ ] Diabetes
- [ ] Stroke / ITA
- [ ] Bleeding disorders
- [ ] Varicose Veins
- [ ] Fractures
- [ ] Headaches
- [ ] Pacemaker
- [ ] Gastrointestinal
- [ ] Asthma
- [ ] Fainting episodes
- [ ] Kidney Disorder
- [ ] Hepatitis: A
- [ ] Respiratory disease
- [ ] Neurological condition
- [ ] Skin conditions
- [ ] Hepatitis: B
- [ ] Tuberculosis
- [ ] Epilepsy
- [ ] Blood Pressure: High
- [ ] Hepatitis: C
- [ ] Cancer
- [ ] Migraines
- [ ] Emotional Disorder
- [ ] Head injury
- [ ] Arthritis
- [ ] Kidney Stones
- [ ] Chronic Fatigue

Other (please specify): _____

Symptom Checklist (please check all that apply):

- [ ] palpitations
- [ ] problems with weight
- [ ] low appetite
- [ ] bleeding gums
- [ ] muscle tension/spasm
- [ ] constant thirst
- [ ] irritability
- [ ] fatigue
- [ ] heartburn/acid reflux
- [ ] urinary incontinence
- [ ] addictions
- [ ] restless leg
- [ ] heat in palms/soles
- [ ] frequent urination
- [ ] easily angered
- [ ] hearing problems
- [ ] always feeling cold
- [ ] urinary tract infection
- [ ] shortness of breath
- [ ] swollen lymph nodes
- [ ] always feeling hot
- [ ] cloudy urine
- [ ] chronic cough
- [ ] water retention
- [ ] fevers
- [ ] blood in urine
- [ ] post nasal drip
- [ ] edema
- [ ] night sweats
- [ ] mouth sores
- [ ] chest pain
- [ ] nausea
- [ ] abnormal sweating
- [ ] tongue sores
- [ ] dry mouth
- [ ] vomiting
- [ ] loose stools
- [ ] skin discoloration
- [ ] dry throat
- [ ] poor circulation
- [ ] blood in stool
- [ ] skin moles
- [ ] chronic runny nose
- [ ] hair loss
- [ ] constipation
- [ ] dry skin
- [ ] tightness in chest
- [ ] brittle hair/nails
- [ ] diarrhea
- [ ] infertility
- [ ] neck pain
- [ ] vision problems
- [ ] mucous in stool
- [ ] high libido
- [ ] poor memory
- [ ] redness in eyes
- [ ] hemorrhoids
- [ ] low libido
- [ ] foggy thinking
- [ ] floaters in eyes
- [ ] gas/bloating
- [ ] depression
- [ ] insomnia
- [ ] bruise easily
- [ ] bad breath
- [ ] apathy
- [ ] difficulty concentrating
- [ ] low back pain
- [ ] bad taste in mouth
- [ ] anxiety
- [ ] dizziness
- [ ] low immune system
- [ ] stress
- [ ] ringing in ears

Other (please specify): _____

Women's Health - Gynecology

Age of your first period _____ Length of menstrual cycle: ____ days Age you underwent menopause (if applicable) _____

Your period flow: ☐ Very Heavy ☐ Heavy ☐ Average ☐ Light ☐ Very Light Is your period regular? ☐ Yes ☐ No

Colour of the flow: ☐ Brown ☐ Purple ☐ Dark Red ☐ Red ☐ Light Red On what day do you ovulate? _____

Any clots? ☐ Yes ☐ No Colour: ☐ Brown ☐ Purple ☐ Dark Red ☐ Red ☐ Light Red

Pain or cramps? ☐ Yes ☐ No Severe? ☐ Yes ☐ No. Nature of pain: ☐ Sharp ☐ Dull ☐ Constant ☐ Burning ☐ Aching ☐ Intermittent ☐ Mixed _____

Date of last period? _____ What day of your cycle are you on? _____ Average length of flow: _____ days

Bleeding between periods? ☐ Yes ☐ No Explain: _____

Any Vaginal discharge not associated with your period? ☐ Yes ☐ No Explain: _____

List any current menstrual symptoms (e.g. PMS, cramps, breast distension, water retention, headaches, nausea, etc.) before, during and/or just after? _____

_____

Any history of sexually transmitted infections? If so, please indicate what and when: _____

Date of last PAP smear, and if any abnormal findings: _____

Menstrual Chart (Please fill in all that apply):	Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	Day 7
Colour: _____							
Volume of Flow: _____							
Pain, Cramps: (Location) _____							
Pain, Cramps: (Intensity) _____							
Clots: (size) _____							
Clots: (colour) _____							
Vomiting: (Check if Yes) _____							
Nausea: (Check if Yes) _____							
Other: _____							

Are you trying to conceive? ☐ Yes ☐ No Do you use birth control? ☐ Yes ☐ No What form? _____

Any chance you are currently pregnant? ☐ Yes ☐ No If **Yes**, at _____ weeks Your due date? _____

Is this your first pregnancy? ☐ Yes ☐ No Are you carrying twins/multiples? ☐ Yes ☐ No

If pregnant, are there any concerns or complications with this pregnancy? _____

If pregnant, are there any symptoms you are experiencing? _____

Have you had any pregnancies? ☐ Yes ☐ No How many? _____ How many children, and ages? _____

Had problems with pregnancy? ☐ Yes ☐ No Please explain: _____

Had any miscarriages? ☐ Yes ☐ No Please provide dates: _____

Had any abortions? ☐ Yes ☐ No Please provide dates: _____

Menopause

List any current menopausal symptoms (e.g. hot flashes, night sweats, insomnia, etc.)? _____

If you are experiencing menopausal symptoms, please describe: _____

Do you have any other women's health concerns? Please specify: _____

Men's Health - Andrology

Do you have any problems with any of the following (please circle)

- ☐ Incontinence
- ☐ Difficult urination
- ☐ Painful urination
- ☐ Dribbling urination
- ☐ Difficulty urinating
- ☐ Urinary incontinence
- ☐ Prostate enlargement
- ☐ Testicular pain
- ☐ Groin pain
- ☐ Infertility
- ☐ Impotence
- ☐ Erectile dysfunction
- ☐ Decreased libido
- ☐ Increased libido
- ☐ Ejaculation disorders
- ☐ Premature ejaculation
- ☐ Nocturnal emissions

Other (please specify): _____

Any history of sexually transmitted infections? If so, please indicate what and when: _____

Date of last prostate exam, and if any abnormal findings: _____

Do you have other men's health concerns? Please specify: _____